MISSOURI STATE BOARD OF NURSING NEWSLETTER

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Message from the President

Charlotte York, LPN, President

RN Renewal Notices to be Mailed February 1, 2009

York

The RN renewal season officially began on February 1, 2009 and ends April 30, 2009. Renewal notices were mailed out starting February 1, 2009. The ability to renew online at the Board of Nursing's web site opened at midnight on February 1, 2009. RN licensure renewal is for a two-year period, expiring April 30th of each odd-numbered year. Missouri law requires that a nurse have an active license in order to practice nursing within the State.

RN nursing licenses may be renewed via the Missouri Board of Nursing's website by selecting *Online Services* and then *Renew a License*. A **PIN** number is required for online renewal. This number can be obtained from the renewal application that was mailed February 1, 2009. If a renewal application has not been received, please contact the Board office at 573-751-0681.

Failure to receive the renewal application does not relieve the licensee of the responsibility to maintain a current license. Per statute, licensees are responsible for keeping the Board of Nursing informed of their current mailing address.

If a license expires, the nurse **must** stop working immediately and cannot begin working again as a nurse until current licensure status can be verified and confirmed. Updated licensure information can be accessed through the Missouri State Board of Nursing's website at http://pr.mo.gov/nursing.asp by selecting *Online Services* and then *Licensee Search*.

The Nursing Shortage—A Call to Action

The United States is in the midst of a nursing shortage that is expected to intensify as baby boomers age and the need for health care grows. Compounding the problem is the fact that nursing colleges and universities across the country are struggling to expand enrollment levels to meet the rising demand for nursing care.

The Missouri State Board of Nursing worked with the Nursing Coalition and the Missouri Department of Health and Senior Services developing a survey in order to gather current statistics related to the shortage. There is an abundance of nursing shortage studies statistics on a national level but not any that are Missouri-specific. Data from this survey will be used to inform state and local decision makers regarding the recruitment, education, and employment of nurses in Missouri.

This survey is included with your renewal notice. Should the online renewal option be chosen, an online version of this survey is available. The information provided in the survey is kept confidential; the identity of individual respondents will not be shared. Completion of the questions is voluntary and does not affect licensure or license renewal but we strongly urge completion of the survey. This data is vital for Missouri lawmakers and

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Executive Director Report

Authored by Lori Scheidt, Executive Director

Scheidt

The 2009 legislative session started on January 7, 2009 and goes through May 15, 2009. The Board of Nursing is not seeking any legislative changes this year.

I can think of two laws that passed recently where nurses did not feel fully informed of the law before it became effective. The Board of Nursing did not introduce either of these laws and as a government agency is charged with enforcing the law as written.

One was the bill that requires all persons and business entities applying for or renewing licenses with the Division of Professional Registration to have paid all state income taxes, and to have filed all necessary state income tax returns for the preceding three years. If a licensee failed to pay taxes or failed to file tax returns their license is subject to suspension within 90 days of being notified by the Missouri Department of Revenue of any delinquency or failure to file. This requirement was enacted in House Bill 600 of the 92nd General Assembly (2003), and was signed into law by the Governor on July 1, 2003.

The other bill was Senate Bill 724 of the 94th General Assembly (2008) and became effective August 28 2008. This bill pertains to controlled substance prescriptive authority for advanced practice registered nurses.

The legislative process is lengthy and changes to bill language are frequently made after bills are fully heard in committee hearings. An important phase of the legislative process is the action taken by committees. It is during committee action that the most intense consideration is given to proposed bills; this is also the time when the people are given their opportunity to be heard. The two most important committees related to professional licensees are the Senate Financial, Governmental Organizations and Elections Committee and the House Special Committee on Professional Registration and Licensing.

How a Bill Becomes a Law

No law is passed except by bill. Bills may originate in either house and are designated as Senate Bills or House Bills, depending on the house in which they originate. No bill (except general appropriations bills) may contain more than one subject, which is to be expressed clearly in its title. No bill can be amended in its passage through either house so as to change its original purpose. No bill can be introduced in either house after the 60th legislative day of a session unless consented to by a majority of the elected members of each house. The governor may request consideration of proposed legislation by a special message. No appropriation bill shall be taken up for consideration after 6:00 p.m. on the first Friday following the first Monday in May of each year.

Introduction of a Bill

Legislation approved by the 1971 General Assembly (H.B. 156) provides for pre-introduction of bills beginning December 1 preceding the opening of the assembly session and continuing up to, but not including, the first day of the

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current resident or

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Important Telephone Numbers

Department of Health & Senior Services (nurse aide verifications and general questions)	573-526-5686
Missouri State Association for Licensed Practical Nurses (*MoSALPN*)	573-636-5659
Missouri Nurses Association (*MONA*)	573-636-4623
Missouri League for Nursing (*MLN*)	573-635-5355
Missouri Hospital Association (*MHA*)	573-893-3700

Number of Nurses Currently Licensed in the State of Missouri

As of January 29, 2009

Profession	Number
Licensed Practical Nurse	23,646
Registered Professional Nurse	91,634
Total	**115,280**

Schedule of Board Meeting Dates Through 2010

March 11-13, 2009
June 3-5, 2009
September 9-11, 2009
December 2-4, 2009
March 3-5, 2010
June 2-4, 2010
September 8-10, 2010
December 1-3, 2010

Meeting locations may vary. For current information please view notices on our website at http://pr.mo.gov or call the board office.

If you are planning on attending any of the meetings listed above, notification of special needs should be forwarded to the Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 or by calling 573-751-0681 to ensure available accommodations. The text telephone for the hearing impaired is 800-735-2966.

Note: Committee Meeting Notices are posted on our web site at http://pr.mo.gov

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other decision makers as they work to effectively identify and resolve issues associated with the nursing shortage and develop comprehensive short and long range state workforce planning strategies to turn the shortage around.

Show Me Response—Online Registration System for Volunteer Health Professionals

Nurses have an opportunity to lend aid following a large scale disaster or other public health emergency by pre-registering, as a health care professional willing to provide services, at www.showmeresponse.org. Health professionals that pre-register as volunteers can be deployed rapidly and effectively in the event of a disaster.

This disaster volunteer registration site is operated by the Missouri Department of Health and Senior Services and allows registration as a volunteer during a disaster or emergency situation. The registration system will collect basic information about the volunteer and the volunteer's professional information such as license number, expiration date, certifications, and specific contact information.

To qualify as a volunteer, the nurse must be a Missouri resident and/or have an active, undisciplined license with the Missouri State Board of Nursing. Upon registration, credentials are checked. All reasonable efforts, in accordance with the federal guidelines for Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), will be made to ascertain the credentials of individuals interested in becoming a volunteer.

During a state or national disaster, this system may receive requests for potential volunteers. If a decision is made to request the services of a volunteer, the selected individual will be contacted through an automated system and asked about availability. An individual can choose to accept or decline any request for activation.

Board of Nursing Nearing 100 Year Anniversary

In March 1909, nearly 100 years ago, the Nursing Practice Act became effective in Missouri. The first Missouri Board State for the Examination and Registration of Nurses consisted of 5 members appointed by Governor Herbert S. Hadley. These 5 nurses, Elizabeth Tooker, RN; Ida Gerding, RN; Maude Landis, RN; Charlotte Forrester, RN; and Fanny E. S. Smith, RN held the first meeting of the Board in December 1909 to adopt the rules and regulations to govern themselves.

The mission of the Board then, as it is today, was to protect the public by development and enforcement of state laws governing the safe practice of nursing.

Legislative Authority

The Nursing Practice Act (NPA) exists to govern and regulate the profession of licensed nurses, set standards for the approval of nursing schools in Missouri, determine the scope of practice of licensed nurses, and define who may use the title of registered nurse (R.N.) and licensed practical nurse (L.P.N.) within the State of Missouri. Rules are promulgated to provide guidance for the Board to carry out the mandate of the NPA. The Board of Nursing has no authority to change the law; changes can only be made by the legislators.

Number of Licensees

The State of Missouri has approximately 91,000 licensed RNs and 24,000 LPNs functioning in a variety of health care settings. About 6,450 of the RNs are also Advanced Practice Registered Nurses (APRNs).

Board Members

Board members are appointed to the Board by the Governor with advice and consent of the Senate when a vacancy occurs either by expiration of a term or resignation of a Board member. There are nine Board member slots; five of whom must be registered professional nurses, two must be licensed practical nurses, one an undesignated member, and one member a voting public member. Every appointment except to fulfill an unexpired term shall be for a term of four years, but no person may be appointed for more than two consecutive terms. The board is entrusted with the duty of ensuring that the RNs and LPNs licensed in Missouri comply with Chapter 335 thus creating an atmosphere of safe and effective nursing care in the interest of public protection. The members of the Board, along with its staff and general counsel are entrusted with the legal responsibility to see that the provisions of the law are carried out effectively, in addition to serving as a policy making and planning group. When administering the NPA and establishing policy, the Board considers the licensee, the patient, the community, the State of Missouri and programs of professional and practical nursing. The Board's primary role is governance while the staff's primary role is management.

Board Member Changes

In the last issue of our newsletter, it was noted that Amanda Skaggs, RNC, WHNP, accepted the position of President of the Missouri State Board of Nursing. Ms. Skaggs' term expired 8/13/2008 and was serving until reappointed or replaced. On November 13, 2008, Kelly Scott, MSN, RN, BC, FNP, was appointed to the Board in the slot formally held by Amanda Skaggs.

There will undoubtedly be more changes to the Board. We currently have a vacant RN board member position and a vacant public member position. We are thankful for the commitment and dedication of all Board members (past and present) that have willing served in these roles. In the 100 years of existence of the Board there has been 149 such individuals.

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session. Bills filed during the pre-introduction period are automatically introduced and read the first time on the opening day of the session.

Bills may also be introduced by any senator or representative during the session. Bills may be written by the legislator or drafted by the staff of the Committee on Legislative Research at the request of a senator or representative. When introduced, a bill is assigned a number and read for the first time by its title by the Senate or House reading clerk. It then goes on the calendar for second reading and assignment to committee by the speaker of the House or the president *pro tem* of the Senate.

A public hearing before the committee to which a bill is assigned is the next step in the legislative process. Except in the case of some unusually controversial, complex or lengthy bills, the bill is presented by its sponsor and both proponents and opponents are heard in a single hearing. When hearings are concluded, the committee meets to vote and makes its recommendations. The committee may: (1) Report the bill with the recommendation that it "do pass;" (2) Recommend passage with committee amendments, which are attached to the bill; (3) Return the bill without recommendation; (4) Substitute in lieu of the original bill a new bill to be known as a committee substitute; (5) Report the bill with a recommendation that it "do not pass" or (6) Make no report at all.

Perfection of a Bill

If a bill is reported favorably out of committee or a substitute is recommended, it is placed on the "perfection calendar" and when its turn comes up for consideration it is debated on the floor of the originating house. If a substitute is recommended by the committee or if committee amendments are attached to the bill, they are first presented, debated and voted upon. Further amendments can then be proposed by other members with their changes designated as House or Senate amendments to differentiate from the committee amendments. When all amendments have been considered, a motion is made to declare the bill perfected. Perfection is usually voted on a voice vote but on the request of five members, a roll call shall be taken. If a majority of members vote to perfect, the bill is reprinted in its original or amended form.

Final Passage of a Bill

After perfection and reprinting, the bill goes on the calendar for third reading and final passage. When the bill is reached in the order of business any member may speak for or against its passage but no further amendments of a substantive nature can be offered. At the conclusion of debate, a recorded vote is taken. Approval of a constitutional majority of the elected members (18 in the Senate and 82 in the House) is required for final passage.

Passage of the bill is then reported to the other house where it is again read a second time; referred to committee for hearing; reported by committee; and third read and offered for final approval. If further amendments are approved, these are reported to the originating house with a request that the changes be approved. If the originating house does not approve, a conference may be requested and members from each house are designated as a conference committee. Upon agreement by the conference committee (usually a compromise of differences), each reports to its own house on the committee's recommendation. The originating house acts first on the conference committee version of the bill. If it is approved it goes to the other house and upon approval there, the bill is declared "truly agreed to and finally passed." If either house rejects the conference committee report, it may be returned to the same or a newly appointed committee for further conferences.

Upon final passage, a bill is ordered enrolled. It is typed in its finally approved form, printed and the bills are closely compared and proofed for errors.

Signing of the Bill

Bills truly agreed to and finally passed in their typed form are then signed in open session by the House speaker and Senate president or president *pro tem.* At the time of signing, any member may file written objections which are sent with the bill to the governor.

Governor's Part in Lawmaking

The governor has 15 days to act on a bill if it is sent to him during the legislative session; and 45 days if the legislature has adjourned or has recessed for a 30-day period.

If he signs a bill, it is returned to its house of origin with his message of approval, then delivered to the Office of Secretary of State. If the legislature is not in session, it is delivered directly to the Office of Secretary of State.

If the governor vetoes a bill, it is returned to the house of origin with his objections. A two-thirds vote by members of both houses is required to override a governor's veto.

If any bill shall not be returned by the governor within the time limits prescribed by Article III, Section 31 of the Missouri Constitution it shall become law in the same manner as if the governor had signed it.

Effective Date of Laws

The 1945 Constitution provides that no law passed by the General Assembly shall take effect until ninety days after the end of the session in which it was enacted, except an appropriation act or in case of an emergency, which must be expressed in the preamble or in the body of the act. Some bills specify the exact date when they are to take effect.

Duties of the Secretary of State

The secretary of state preserves the finally typed copy of the law. All the laws are bound together in one volume at the close of each session and seldom are seen unless some question arises. Prior to binding of the laws, the secretary of state publishes annually a volume of "*Laws of Missouri,*" which is distributed to members of the General Assembly, state officials and other interested persons.

The general statute laws are revised by the revisor of statutes in the Office of the Committee on Legislative Research, digested and promulgated. These are known as the *Revised Statutes of Missouri*. Under legislation, the Committee on Legislative Research also publishes annual supplements to the statutes to include changes in laws since the last revision.

Your Role in the Legislative Process

Nurses represent over 28% of professionals licensed within the Missouri Division of Professional Registration.

The Fall 2003 issue of *John Hopkins Nursing* indicated that "by some estimates, 1 of every 45 potential voters is a nurse. But in the legislative arena, the nursing profession lacks the clout these numbers suggest."

We urge you to study all facets of the issue being considered and know your facts. Be able to tell your legislator what impact a bill will have on his or her constituents. Know the opposing viewpoint. Every issue has two sides.

As a licensed professional, you do have a voice in shaping the future of health care. You can have a face to face meeting, call, write or e-mail your legislators. Let your legislators know how to reach you, your area of expertise and that you are willing to give them information on issues related to nursing. You can find information about the status of bills and how to contact legislators at http://www.moga.mo.gov/

References:

Missouri Senate's web site http://www.senate.mo.gov/bill-law.htm. Accessed December 9, 2008.

Investigations Corner

Authored by Quinn Lewis, Investigations Administrator

Lewis

It is the responsibility of nursing professionals who practice nursing to provide the best of care. According to the Institute of Medicine, "Medical errors cause as many as 98,000 deaths each year in hospitals alone." This month's case of the quarter is an example of a medication error, which subsequently resulted in patient harm. The patient did not die but because of the medication error, the patient's life has been altered forever.

The case began when a patient was admitted to the ICU for a diagnosis of allergic reaction on Friday. Nurse A came into the patient's room with a vial of 1-1000 strength of epinephrine. Nurse A said she was going to draw up 0.6cc of the medication and if the patient needed it she would push out 0.3cc and the patient would get the correct amount. It is important to note that the order was for 0.3cc. Nurse A drew up the 0.6cc and left the syringe in the patient's room by the bedside, just in case the patient needed it.

The patient had had an uneventful night. Nurse B took over the care on Saturday. Nurse B entered the patient's room and pulled a syringe containing saline from her pocket that had been drawn up prior to entering the patient's room. Nurse B told the patient that she was going to flush the IV. The patient was not having a reaction at this time. Nurse B then laid the flush syringe down on the bedside table beside the epinephrine syringe left by Nurse A in order to disconnect the IV medication. Nurse B then picked up the epinephrine syringe instead of the flush and injected it into the patient's IV port. The patient immediately started having convulsions and subsequently had a stroke.

Information gathered during the investigation:

INTERVIEW OF CHIEF NURSING OFFICER:

The CNO stated that Nurse A was the first nurse to care for the patient on Friday. Nurse A drew up 0.6cc of epinephrine and placed it at the patient's bedside in case the patient had an attack and needed the epinephrine immediately.

The CNO said that the doctor's order was for 0.3cc of epinephrine; but the syringe was filled with 0.6cc of epinephrine and left at the bedside and it was not labeled.

The CNO stated that when Nurse A went off duty, Nurse B took over the care of the patient. Nurse B drew up a saline flush in a syringe and went to the bedside of the patient, put the saline syringe on the bedside table beside the epinephrine while she prepared the patient. Nurse B then noticed there were two syringes on the bedside table, neither of which was labeled. Nurse B picked up the saline syringe and threw it away. She then picked up the other syringe, containing 0.6cc of epinephrine, and injected the entire contents into the IV.

The CNO stated that, at the time of the medication error, there was no policy in place relating to the labeling of individual dose syringes. As a result of the medication error, there was a root cause analysis meeting, which resulted in the formulation of a policy requiring all individual dose syringes be labeled.

Nurse A and Nurse B attended the root cause analysis meeting and they both were very regretful and sorry for the mistake. Nurse A and Nurse B continue to be mindful of the mistake and the outcome.

INTERVIEW WITH NURSE A:

The patient came in with an unknown etiology but it was made known that when the patient was having a reaction there was not much time to react, so you had to get the epinephrine to the patient immediately.

The patient had a good night. The patient then called Nurse A into the room and said she was starting to have difficulty. Nurse A went to get the epinephrine and the Benadryl. When she got back to the room the patient said that she would rather wait before taking the epinephrine, because it was not that bad. Nurse A decided to give the patient Benadryl IV, and keep the epinephrine in her pocket since that was the only epinephrine the patient had in their drawer. Any other epinephrine would have to be obtained from the pharmacy. Nurse A then decided to put the syringe with the epinephrine on the bedside table so it would be readily available in case the patient worsened and needed the epinephrine. Nurse A said that she usually taped the vial to the syringe, but for some reason, did not do it this time. Nurse A said that she was going to throw the syringe away, but there was no additional epinephrine readily available in case the patient needed it, so she just left it on the patient's bedside table.

Nurse A stated that she told oncoming Nurse B about the syringe containing epinephrine on the patient's bedside table because it was the last one in the patient's drawer. Nurse A said that she told Nurse B that if she wasted the epinephrine syringe, she would have to go to pharmacy to get more.

Nurse A stated that she was very sorry and she never intended to hurt the patient. If there was a way to go back and change things, she would. She said that she would never make that mistake again.

INTERVIEW WITH NURSE B:

Nurse B stated that she was advised by Nurse A that she left a syringe of epinephrine on the patient's bedside table, but she was not told the syringe was not labeled, or how much medication was in the syringe.

Nurse B said that she did an initial flush and hung the piggy back. When she went back into the room to do a flush, she took the syringe with the saline flush with her and laid it on the bedside table beside the epinephrine. Nurse B stated that neither syringe was labeled.

Nurse B said that she laid the syringe on the bedside table so she could disconnect the IV medication. Nurse B stated that when she went to pick up the syringe to do the flush, she noticed that there were two syringes on the bedside table. She said since neither of the syringes was labeled and that the order was for 0.3cc of epinephrine and since the flush syringe had been used and it had 1cc left, she thought that the flush syringe should have the most in it. Nurse B threw away the syringe that had the least amount of clear liquid in it. Nurse B said that she began to do the flush by injecting the entire amount into the IV and then left the room. Nurse B said that the patient immediately called her back into the room, at which time the patient started having convulsions.

Nurse B said that she was very sorry about what happened and wishes that she would have done things differently.

INTERVIEW OF THE PATIENT:

The patient said that she would like to emphasize that Nurse B looked at both syringes and stated "I have a 50/50 chance." Nurse B then picked up one syringe, threw it away, and used the other one. The patient stated that when Nurse B injected the epinephrine in her IV, she immediately had an effect, and was in a great deal of pain.

The patient verbalized that she could not understand why someone would take a 50/50 chance of giving a patient the wrong medication, especially when the wrong one could, and in most cases would, kill the patient. The patient said that she continues to have numerous health problems because of this incident.

After reading the above case, I'm sure most of you have identified several preventative measures that could have been taken to avoid this tragic accident. I hope those of you who are nurses take the time to discipline yourselves to use safe medication administration practices; someone's life could depend on it.

Nurses

Building A Healthy America

Education Report

Authored by Bibi Schultz, RN MSN, Education Administrator

Missouri State Board of Nursing
Education Committee Members:
- Teri Murray, PhD, RN, Chair
- Charlotte York, LPN

Clinical Preceptors


Schultz

Nurse Educators across the state are dedicated to providing nursing students with most valuable clinical experiences. While planning educational experiences which provide students with realistic patient assignments, educators often call on clinical nurses to serve as clinical preceptors. Careful preceptor/student selection is essential to student learning and invaluable to patient safety. While students, patients and nurses may greatly benefit from such precepted clinical experiences, Missouri State Board of Nursing (MSBN) regulation guidelines should be followed.

As nurse educators plan such clinical experiences, selection of clinical preceptors should occur in concert with the clinical facility. Preceptors may be used as role models, mentors and supervisors of students. Preceptors should never replace faculty, but assist faculty to help students achieve designated clinical objectives. Preceptors should not be utilized in entry-level clinical experiences and precept no more than two students at a time. Nursing programs should provide clinical nurses with written policies describing duties, roles and responsibilities of faculty, students and preceptors. Clinical objectives for each experience should also be provided. Preceptors should provide feedback to faculty regarding student performance; yet final student evaluation should remain the responsibility of faculty. Faculty should be readily available to students and preceptors and all should meet periodically to assure optimal student and patient outcomes.

The Missouri Nursing Practice Act requires clinical preceptors for students enrolled in professional nursing programs to possess Missouri licensure as a registered professional nurse with at least one (1) year of experience in the area of clinical specialty for which the preceptor is used. Preceptors for students enrolled in programs of practical nursing may be licensed as a registered or licensed practical nurse in Missouri with similar levels of clinical experience.

Missouri nursing students, patients and nurses may greatly benefit from optimally managed, precepted clinical experiences. As preceptors assist nursing faculty to provide well-rounded realistic clinical experiences for future nurses, it is essential to assure clinical assignment models designed to optimize student preparation for practice as well as provision of safe and effective nurse/patient situations.

Missouri Nursing Practice regulations guiding precepted clinical experiences are accessible on the MSBN website at http://pr.mo.gov under rules. Chapter 2, Minimum Standards for Programs of Professional Nursing, section 20 CSR 2200-2.085, as well as Chapter 3, Minimum Standards for Programs of Practical Nursing, section 20 CSR 2200-3.085, provide regulatory guidelines for the different levels of nursing education.

Licensure Corner

Authored by Angie Morice, Licensing Administrator

Missouri State Board of Nursing
Licensure Committee Members:
Autumn Hooper, RN, Chairperson
Charlotte York, LPN

New Rule for Nurses Educated Outside the United States


Morice

Effective December 30, 2008, anyone wanting to become licensed in Missouri that was educated outside the United States will need to provide a course by course evaluation report received directly from a credentials evaluation service approved by the board or a Commission on Graduates of Foreign Nursing Schools (CGFNS) certificate. This rule includes Canada and Puerto Rico.

RN Renewals Notices

Renewal notices were mailed beginning February 1, 2009. The fee to renew your RN license is $60. You have the option to either renew by mail or online. Please make sure all questions are answered and the renewal notice is signed. Failure to do so, will cause the renewal to be rejected and mailed back to you and may result in your license not being renewed by the expiration date.

To renew online, you will need to go to the website at http://pr.mo.gov. The instructions for online renewal are easy. You need your PIN number and a credit card. We accept MasterCard, Visa, Discover and American Express. The total cost will be $62.50 which is the $60.00 renewal fee and a $2.50 processing fee that is charged by the credit card vendor.

The PIN number is a unique number assigned to you. It can be found on your paper renewal notice. In order to protect your personal information, your PIN number will not be provided to you over the phone. You can request your PIN number by written request with your name, license number, signature and current date and mailing address. Your PIN number will remain the same for every renewal in the future.

If you have not received your renewal notice in the mail by the end of February, you will need to fax a request for a duplicate renewal notice to be mailed or faxed to you. The request needs to include your name, license number, address, fax number, request for a duplicate renewal notice and your signature. Please fax your request to 573-751-6745 or 573-751-0075.

324.010 No Delinquent Taxes, Condition for Renewal of Certain Professional Licenses

All persons and business entities renewing a license with the Division of Professional Registration are required to have paid all state income taxes and also are required to have filed all necessary state income tax returns for the preceding three years. If you have failed to pay your taxes or have failed to file your tax returns, your license will be subject to immediate suspension within 90 days of being notified by the Missouri Department of Revenue of any delinquency or failure to file. If you have any questions, you may contact the Department of Revenue at 573-751-7200.

Name and Address Changes

Please notify our office of any name and/or address changes immediately in writing. The request must include your name, license number, your name and/or address change and your signature. Methods of submitting name and/or address changes are as follows:
- By faxing your request to 573-751-6745 or 573-751-0075.
- By mailing your request to Missouri State Board of Nursing, PO Box 656, Jefferson City, Missouri 65102.

Contacting the Board

In order to assist you with any questions and save both yourself and our office valuable time, please have the following information available when contacting the Board:
- License number
- Pen and paper

SHOW-ME RESPONSE
ShowMeResponse.org
Registry of Volunteer Healthcare Professionals

Disasters call for heroes. Answer the Call.

The Missouri Department of Health and Senior Services is pleased to announce
Show-Me Response, a Registry of Volunteer Healthcare Professionals
www.ShowMeResponse.org

The Missouri Department of Health and Senior Services, Center for Emergency Response and Terrorism (CERT) announces the December 1, 2008 activation of Show-Me Response, an online registration program for healthcare professionals who are interested in volunteering in the event of a natural disaster or other large-scale public health crisis in Missouri. During a public emergency, healthcare volunteers are essential to help coordinate and deliver services for medical assessment, medication dispensing, immunization, counseling, special needs sheltering, and more.

When volunteers register for Show-Me Response, they make themselves available for contact in the event of a disaster should their area of expertise be needed. Once contacted, each volunteer will be able to choose the type and level of participation. The system is safe and secure, and any information a volunteer provides will be protected for privacy.

Show-Me Response will collect and check licensing and credential information so it can be readily available for the Missouri Department of Health and Senior Services staff to assist in the notification and activation of qualified medical volunteers.

Healthcare professionals can register as volunteers on the Show-Me Response web site at www.ShowMeResponse.org.

"Disasters begin and end locally, and trained and prepared volunteers play a key role in responding to a crisis," said Mike Sampson, director of the Center for Emergency Response and Terrorism. "Volunteers on the local level can help provide an immediate and effective response. Any disaster typically involves health concerns, increasing the need for trained volunteers."

For additional information, please contact ShowMeResponse@dhss.mo.gov or contact:

Carole Schutz, MS, RN
Program Coordinator
PO Box 570
Jefferson City, MO 65102-0570
Office 573-526-0577
Email carole.schutz@dhss.mo.gov

Become a volunteer. Go to **www.ShowMeResponse.org** and help in times of public crisis.

The Legal Perspective

Renewal Time is Right Around the Corner

Authored by Mikeal R. Louraine, B.S., J.D.
Senior Legal Counsel

Louraine

Since RN licensees will be getting their renewal notices about the same time they get this newsletter, I thought I would use this article to address one of the biggest questions that comes up each year during renewals. We always have some licensees who are unsure how to answer the question, "*Have you ever been convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any crime, whether or not sentence was imposed (excluding traffic violations)*?" Fortunately, the great majority of our licensees has never run afoul of law enforcement and can quickly answer 'No' and move on. If you are a part of that fortunate majority, you may be excused from reading the remainder of this article. For those of you that have had the bad luck to end up in criminal court and want to fulfill your obligation to honestly report the incident to the Board, please read on.

The biggest problem that licensees run into is whether or not they are required to report an incident that resulted in a suspended imposition of sentence (SIS). Basically, in an SIS situation, the criminal defendant is placed on probation. If that probation is successfully completed, the defendant is not formally convicted of the crime. Other states have similar plea arrangements but have other names for them. In Illinois, I believe they're referred to as 'court supervision'. Regardless of the different states' names for this plea arrangement, they, like an SIS, are required to be reported to the Board when renewing your license. Many licensees who have received the benefit of an SIS incorrectly believe that they don't have to report these incidents to the Board. They come to that mistaken belief because they only read the first part of the above question. They read, "Have you been convicted…" and believe that because they have not been convicted, they do not need to report. If the question ended there, they would be correct. However, the question goes on to ask whether or not the licensee has, "…pled guilty or nolo contendere…" (In case you were wondering, 'nolo contendere' is Latin for 'no contest') In order for a Court to have the ability to grant a suspended imposition of sentence, there must be a guilty plea. Therefore, the incident should be reported to the Board.

Another area that sometimes causes confusion is when the licensee has been required to participate in a drug court program. If the licensee has pled guilty and been sentenced to probation which includes drug court, this needs to be reported to the Board. Similarly, if a licensee received an SIS and has been ordered to participate in drug court, again, this needs to be reported to the Board. The confusion arises when the drug court program is a 'pre-plea' drug court. This means that there has been an agreement between the licensee and the prosecutor that the licensee will participate in drug court. This agreement is reached before the licensee has entered a plea in the pending criminal case. Therefore, there has not been a conviction, guilty plea or no contest plea. The above question can, therefore, be honestly answered 'No'. However, there are two other questions that come into play. First, "*Do you currently, or did you within the past five years, use any prescription drug, controlled substance, illegal chemical substance, or alcohol, to the point where your ability to practice as a registered professional nurse would be affected?*" If a licensee is in a position where they are entering a drug court program, it's difficult to imagine that they can honestly answer this question with a 'No'. The next question, *"Are you now being treated, or have you been treated within the past five years, through a drug or alcohol rehabilitation program?"* Drug court would certainly qualify as a drug rehabilitation program and the licensee should answer affirmatively.

If you have a question about whether or not something should be reported, you have a couple of options. First, err on the side of caution and go ahead and report the incident. You will never be penalized for being overly honest. The same cannot be said for failing to report an incident that should have been reported. If you fail to report something that the Board requires you to report, the Board could seek to discipline your license under §335.066.2(3) RSMo, which states that the Board may file a complaint against a licensee for, "*Use of fraud, deception, misrepresentation or bribery in securing any certificate of registration or authority, permit or license issued pursuant to sections 335.011 to 335.096…*" Failure to report a criminal conviction or participation in drug court could easily be interpreted as fraud, deception or misrepresentation. Again, err on the side of caution. Second, if you are unsure about whether or not to report an incident on your renewal, you may contact the Board and discuss the issue with either myself or Angie Morice, the Licensing Supervisor.

Every year, it seems we have some licensees who are unsure of whether or not they need to report and end up being investigated for failing to report guilty pleas and/or drug court participation. Hopefully, this article will give you a little guidance if the question arises for you. If nothing else, remember: 1) err on the side of caution; and 2) if you have questions, ask.

Discipline Corner

Authored by Janet Wolken, MBA, RN
Discipline Administrator

Missouri State Board of Nursing
Discipline Committee Members:

- Charlotte York, LPN, Chair
- Autumn Hooper, RN

Wolken

Probation Requirements

When a nurse is placed on probation the terms of the probation are defined in the Settlement Agreement or Board Order. For the purpose of this article the disciplinary document will be referred to as an agreement. Every disciplinary agreement is different based on the conduct of the licensee.

Each licensee that is placed on probation is required to meet with the Board or its professional staff at such times and places as required by the Board. If the Licensee does not receive notice of a meeting with the Board within one month after the effective date of the agreement then the licensee must contact the Board office. The discipline section mails out an appointment letter with the date, time and place of the meeting with the executed discipline agreement. Included in this mailing are the quarterly due dates and the forms required for use to fulfill portions of the agreement. If you would like to view the forms they may be found at http://pr.mo.gov/nursing-monitoring.asp. The meeting takes place at the Board Office in Jefferson City, with the Discipline Administrator. At the meeting the requirements of the agreement are reviewed.

Each licensee on probation shall not violate the Nursing Practice Act, shall renew their license immediately and shall not allow the license to lapse. They may place their license on inactive status but the conditions of discipline will continue to apply if the license is inactive.

The licensee shall inform the Board within ten days of any change of home address or home telephone number.

The licensee shall advise any employer or potential employer of the probationary status and shall provide a copy of the entire disciplinary agreement to any employer or potential employer. The licensee must also keep the Board informed of their current place of employment and of any changes of employment. This requirement also includes non nursing employers such as retail stores, restaurants, etc.

Employers must fill out an employer evaluation form on a quarterly basis. Two forms are available, one if the nurse is working in a nursing position (Nursing Employment Evaluation Form) and the other is a Non-nursing Employment Evaluation Form. The forms must be sent to the Board Office by the supervisor. If the licensee ends employment with an employer through resignation or termination a final evaluation form must be submitted by the supervisor within six weeks following the last day of employment. If a licensee is not employed, they must submit a signed affidavit on a quarterly basis stating the period of unemployment.

When licensees are employed in a nursing position the board may place employment restrictions on their nursing practice. The restrictions may include any of the following that the Board feels necessary to provide protection to the public:

- Licensee shall not carry narcotic keys, administer, possess, dispense, or otherwise have access to controlled substances.
- Licensee shall only work as a nurse at a facility where there is on-site supervision by another nurse or physician.
- Licensee shall not work for a temporary employment agency.
- Licensee shall not work home health.

The Board members carefully review the conduct of the licensee and decide what restrictions they feel necessary; the licensee is responsible for following the restrictions.

The Board may require the licensee to undergo a thorough chemical dependency and/or mental health evaluation. The evaluation must be performed by a licensed professional and the Board must be informed if further treatment is necessary.

The Board may require continuing education hours be completed in specific topic areas. The certificate of completion for the education hours and the course objectives must be submitted to the Board Office by a set due date.

The Board may require drug screens. The Board contracts with a third party administrator for the drug screens. The licensee is required to call or check in by computer between 0500 and 1600 on a daily basis, 365 days of the year. At any time the licensee may be required to submit a specimen, they must report to a lab that same day to give the specimen.

To successfully complete the probationary period the licensee must comply with all of the requirements in the agreement. If they do not comply then a probation violation hearing will be scheduled to allow the licensee the opportunity to inform the Board why they were unable to comply. At the conclusion of this hearing the Board will decide if further discipline is necessary for the protection of the public.

The terms listed in this article are general terms and they may be altered on an individual basis.

Practice Corner

Authored by Debra Funk, RN
Practice Administrator

Missouri State Board of Nursing
Practice Committee Members:

- Autumn Hooper, RN
- Teri Murray, PhD, RN

Communication Is Key

Funk

So much of what we do as nurses is dependent upon or heavily impacted by the utilization of effective communication. Just think about what you do in a day's time for your patients. Shift to shift report, hand off report to an ancillary department, clarification of a physician's order over the phone, documentation of a physical assessment, introduction of yourself to your patient at the beginning of a shift, or notifying the next of kin of a serious injury to their loved one, only scrapes the surface. If any of this information is poorly communicated or not communicated at all, the results could be catastrophic. And we must also remember that the way we communicate to others will leave an impression about the kind of customer service you and your facility provide.

In today's healthcare environment, we have so much information to process and pass on to others who are vital to the care of our patients. But in addition to the necessity of moving all this information around we must also keep in mind the patient's confidentiality. It is truly amazing when you break it all down and try to comprehend how significant communication really is in the provision of safe quality patient care.

Included is a reprint of an article from the November 2008 Arkansas Board of Nursing Newsletter that addresses the topic of the transition of patient care across settings.

Transitions of Care: Improving Patient Care Across Settings

by Pam Brown, RN, BSN, CPHQ and Paula Dyer, RN, Reprinted with permission from the Arkansas Board of Nursing.

An emerging focus in health care is how providers communicate across care settings the information essential to managing the patients' care. This is essential as many patients have increasingly more complicated and chronic needs, and thus frequently transition between systems of care.

The term "transitions of care" applies primarily to the chronically ill who are at risk for increased use of health care services. Transitions of care combine the best elements of inpatient care, home health, disease management and case management in a personalized health care system to keep these patients as healthy as possible while reducing the use of costly services, such as the emergency room and inpatient hospitalization.

Transitions of care can be complex. A patient might receive care from a physician in an outpatient setting, and then be admitted as an inpatient to a hospital before moving to a skilled nursing facility. Because a patient's journey in health care involves encounters with multiple disciplines and multiple persons within those disciplines, the ownership of this process can be dropped.

An example of this can be seen in patient care after discharge. Medicare patients express greater dissatisfaction with discharge-related care than any other aspect of medical care. Within 30 days of discharge, 17.6 percent of Medicare beneficiaries are re-hospitalized. Of these beneficiaries, 64% receive *no post-acute care* between discharge and readmission. The Medicare Payment Advisory Commission (MedPAC) estimated that up to 76 percent of these readmissions may be preventable.

Nationwide, most organizations, experts and stakeholders agree that three main principles must exist for the transition of care process to succeed: accurate communication, provider accountability and patient involvement.

Accurate communication: Poor communication is often found to be the root cause of patient safety and quality concerns within medical care organizations. Communication of information about a patient's treatment plan and expectations of follow-up should be accurate, clear and timely. This will ensure that the patient's needs are met across the continuum of care. Effective communication plays an essential role in assuring provider accountability and patient involvement during transitions of care.

Provider accountability: Accountability among providers will help ensure that all providers involved in a patient's care have access to information at each phase of care, and are aware of when a transition occurs. Identifying and standardizing essential information will ensure improved transitions of care. Elements to include are:

- An accurate list of medications (utilize a "medication reconciliation" process).
- Name and contact information for the patient's primary physician(s).
- Expectations for follow-up.
- A list of treatments or procedures the patient has received.
- Signs and symptoms to report.
- Discharging facility/unit/nurse.

Patient involvement: The patient and his or her family should always be informed about the details of the transition process. Failure to do so can have a negative impact on patient self-management. A strong provider/patient relationship helps to ensure a patient's involvement and understanding. The patient should:

- Have access to his/her Personal Health Record.
- Be familiar with the discharge preparation checklist.
- Receive a self-activation and management session with a transition coach.
- Receive follow-up visits from the transition coach at home or in a skilled nursing facility, along with accompanying phone calls designed to sustain the first three components and provide continuity.

Focusing on the critical transitions of patients and their caregivers across health care settings and among providers is a promising approach to enhancing transitions of care and improving health care quality.

Update on APRN Controlled Substance Prescriptive Authority

The Task Force that has been working on the rules that the Board of Nursing is responsible for promulgating has submitted a draft to the Board for review. This preliminary review was accomplished at the December 2008 Board meeting. Comments will be sent back to the Task Force. Bureau of Narcotics and Dangerous Drugs (BNDD) has been working on their rule changes as well. Work is also underway to clarify and revise the collaborative practice rules. Once completed, the draft will be sent to the Board of Healing Arts and the Board of Nursing and then to the Collaborative Practice Task Force for final approval.

Patient Safety NURSING Quality

Summary of Actions December 2008 Board Meeting

Education Matters

Curriculum Changes

- Request to place some non-nursing courses on-line was received from Sanford Brown College, Associate Degree Program, #17-421 was acknowledged by the Board
- Request to increase the program hours from 1334 total hours to 1384 total hours was approved for Kirksville Area Technical Center, PN Program #17-186.
- Request to change the curriculum hours from 1463 to 1356 hours was approved for Warrensburg Area Career Center, PN Program #17-172.

Enrollment Changes

- Request to increase enrollment from 25 to 30 students with 2 alternates was approved for Bolivar Technical College, PN Program #17-121.

New Programs

- The proposal to establish a new Practical Nursing Program from Carthage Technical Center was accepted.
- A Letter of Intent to establish a new Practical Nursing Program from Metro Business College was acknowledged.
- A Letter of Intent to establish a new LPN to RN Bridge Program from Pike/Lincoln Technical Center, PN Program #17-168 was acknowledged.
- A Letter of Intent to establish a part-time LPN to RN Bridge Program from Bolivar Technical Center was acknowledged.
- A Letter of Intent to establish a new Practical Nursing Program from Clinton Technical School was acknowledged.

Surveys

- Numerous survey reports were reviewed and accepted.

Discipline Matters

The Board held 8 disciplinary hearings and 15 violation hearings.

Licensure Matters

The Licensure Committee reviewed 53 cases. Results of reviews as follows:

Applications Approved—3
Applications Approved with letters of concern—18
Applications Approved with probated licenses—12
Applications tabled for additional information—4
Applications Denied—12
Renewal Application Denied, License Revoked—2
Censures—2

Disciplinary Actions**

*Pursuant to Section 335.066.2 RSMo, the Board "may cause a complaint to be filed with the Administrative Hearing Commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit, or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his certificate of registration or authority, permit or license" for violation of Chapter 335, the Nursing Practice Act. **Please be advised that more than one licensee may have the same name. Therefore, in order to verify a licensee's identity, please check the license number.*

PROBATIONARY LICENSE

Listed below are individuals who were issued an initial probationary license or had their expired or inactive licenses renewed on a probationary status by the Board during the previous quarter with a brief description of their conduct.

Name	License Number	Violation	Effective Dates of Restricted License
Becky Sue Lankford Farmington, MO	**PN2008031815**	On September 20, 2006, Licensee pled guilty to the Class A Misdemeanor of Possession of a Controlled Substance (Marijuana).	10/14/2008 to 10/14/2010
Janet L Lunn Hazelwood, MO	**PN026175**	Licensee developed an addiction to Percocet. In August of 2006, Licensee voluntarily entered rehabilitation.	11/27/2008 to 11/27/2009

CENSURE

Listed below are the individuals who were given the discipline of censure. This is the least restrictive discipline. The imposition of censure acts as a public reprimand that is permanently kept in the licensee's file.

Name	License Number	Violation
Jennifer A Diaz Liberty, MO	RN2005026731	Licensee failed to call NCPS on twenty-three (23) days. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of May 20, 2008. The Board did not receive proof of support group attendance by the first documentation due date of February 20, 2008 or the subsequent documentation date of May 20, 2008.
Thomas J Jacob Saint Louis, MO	**RN107619**	On August 23, 2006, Licensee entered an Alford plea to one count of sexual misconduct in the second degree.
Tracy G Kaddouri Ballwin, MO	**RN2008027933**	Licensee practiced nursing in the State of Missouri from July 5, 2007 to August 6, 2008 without a current, valid license.
Mary Jo Seeley Kansas City, MO	**PN026632**	Licensee was hired on March 5, 2007 Licensee saw clients through May 3, 2007. Licensee did not return the client's chart to the agency.
Sally M Tunison Saint Charles, MO	**RN096407**	On September 20, 2007 Licensee transported two separate patients to the cardiology floor where Licensee failed to notify the accepting nurse of the patients' arrival to the floor. Licensee also failed to place either patient on the cardiac monitor. Both patients had written physician's orders for cardiac monitoring.
Pauline P Woolman West Plains, MO	**PN039852**	From November 10, 2007 to November 13, 2007, a resident received six doses of Lovenox along with her scheduled Coumadin. The physician's orders stated that daily labs had to be drawn to monitor the effectiveness of the Coumadin. Licensee administered the Lovenox without drawing the daily labs.

The Board of Nursing is Requesting Contact from the Following Individuals:

Michelle Burch—RN 2000162362
Gladys Warrior—PN 055206
Elizabeth Mott—RN148141
Kathy Skeels-Stewart—RN144477
Adrianna Wolverton—RN129667
Diana McFatrich—RN145424
Tina Campbell—RN110664
Charlene Franken—RN2000163726
Tammy Wilcox—RN111848
Stephanie Foster—RN2000161015
Tymber Dawn Spray—RN2003024636
Maria Kleine—RN119983
Thomas Tucker—RN098389
Troy Hobbs—RN2001022470

If anyone has knowledge of their whereabouts, please contact Beth at 573-751-0082 or send an email to nursing@pr.mo.gov

Missouri Moves Closer to Accurate Medical Error Data and Prevention

Missouri Center for Patient Safety receives federal designation to help

JEFFERSON CITY, Mo.—Effective Nov. 5, Missouri will be among the first ten organizations announced as using a new federal program to learn how, when and why medical errors happen across the state.

On Wednesday, Nov. 5, the Missouri Center for Patient Safety will be designated as an official Patient Safety Organization (PSO). This designation allows the Center to safely collect and report information about medical errors.

"Until now, there was no system to obtain reliable data that tells us how often medical errors occur in Missouri. To get it, health care providers need somewhere to openly report errors, near-errors and best-practices. As a PSO, the Missouri Center for Patient Safety can now start collecting this data. Then we can begin analysis and reporting, and start answering questions about the safety of health care in Missouri," said Becky Miller, executive director of MOCPS.

"There is nothing like this in our state right now. Knowing when and why medical errors happen in Missouri is the first step towards making real progress in fighting them," Miller said.

Federal PSO requirements are defined in the Patient Safety and Quality Improvement Act of 2005. The PSOs will form a network of organizations across the nation to encourage reporting of errors and increase knowledge about why errors occur and how they can be prevented. The federal government estimates PSOs will collectively reduce preventable adverse events by up to 3%, saving up to $435 million in health care costs within their first five years of operation.

As a designated PSO, MOCPS will expand on its work over the past three years to support and facilitate ongoing statewide patient safety improvement; increase provider and consumer knowledge about medical errors and decrease medical errors and health care costs.

Missouri is one of the first states to have a listed PSO. The designation is given through the Agency for Health Research and Quality and the U.S. Department of Health and Senior Services.

About MOCPS

As a private, not-for-profit corporation, the Missouri Center for Patient Safety (MOCPS) is dedicated to fostering change throughout Missouri's health care systems. Based in Jefferson City, the mission of MOCPS is to improve health care quality and patient safety in collaboration with health care providers, physicians, purchasers, consumers and government. Online at www.mocps.org.

PROBATION

Name	License Number	Violation	Effective Dates of Probation
Kathleen M Abkemeier Imperial, MO	**RN130554**	On August 10, 2007, Licensee was requested to submit to a drug and alcohol test which tested positive for THC, a metabolite of marijuana.	11/4/2008 to 11/4/2010
Shaunte Jenean Allen Saint Louis, MO	**RN2007004358**	On September 18, 2007, Licensee submitted to a drug screen and the results were positive for marijuana.	9/24/2008 to 9/24/2010
Cheryl Rae Bell Elkins, AR	**RN2007013131**	On August 10, 2007, Licensee submitted to a urine drug screening test as part of a pre-employment hiring process which tested positive for THC, a metabolite of marijuana.	11/4/2008 to 6/26/2009
Patricia A Eichenlaub O Fallon, MO	**RN088232**	On June 22, 2007, Licensee voluntarily sought treatment for alcohol and cocaine dependence. Licensee entered into a Return to Work Agreement. On January 3rd and January 4th, 2008, Licensee self-reported relapsing on alcohol.	10/22/2008 to 10/22/2013
Gregory W Evans Evansville, IN	**RN129504**	Licensee violated the terms of the disciplinary agreement by not calling in to NCPS, inc on 26 days.	10/2/2008 to 10/2/2013
Linda L Golliday Park Hills, MO	**RN2000168576**	Licensee's husband reported to the Missouri State Board of Nursing that Licensee had an inappropriate relationship with an inmate while Licensee was employed at the Department of Corrections. Licensee opened a P.O. Box so that she could receive letters from the inmate and Licensee gave cash to the inmate. Witnesses at Licensee's employment stated they felt that Licensee and Inmate were having an inappropriate relationship.	9/2/2008 to 9/2/2009
Tanya L Graczyk O Fallon, MO	**RN145671**	Licensee's supervisor noticed that Licensee's documentation became sloppy and erroneous, creating inconsistencies in her narcotic counts and charting. A random chart assessment for two of Licensee's shifts on or around February 2005 identified nine charting inconsistencies. These inconsistencies included the waste of morphine without a witness and data entry errors involving the failure to note on patient medication administration records the administration of morphine, Oxycodone, and Chlordiazepoxide taken from storage.	11/25/2008 to 11/25/2010
Carolyn E Harrington Saint Louis, MO	**RN2000164704**	Licensee was required to contract with NCPS, Inc. Since the beginning of her disciplinary period to the filing of the probation violation complaint, Licensee failed to call in to NCPS on thirteen (13) days. On March 26, 2008, Licensee failed to report to a laboratory to provide the requested sample. Licensee is required to abstain completely from the use or consumption of alcohol. On May 14, 2008, Licensee submitted a urine sample the test was positive for the presence of ethyl glucuronide, a metabolite of alcohol.	9/18/2008 to 9/18/2013
Nicole D Harris Crane, MO	**PN2001028007**	On January 5, 14, 26, and 31, 2005 and February 8, 2005 Licensee called in a prescription for Vicodin for herself. On January 7, 2005 and February 3 and 11 2005, Licensee called in a prescription for Vicodin for her husband. On February 14, 2005, Licensee called in a prescription for Vicodin for her mother. On June 24, 2005, Licensee was arrested in Stone County, Missouri, for felony possession of methamphetamine. On March 25, 2007, Licensee completed her drug treatment program through Stone County Drug Court.	10/3/2008 to 10/3/2013
Marie Elizabeth Lasater Licking, MO	**RN2003022718**	On September 23, 2005, Licensee submitted to a for cause drug screen, which tested positive for Fentanyl. Licensee misappropriated Fentanyl for her personal consumption.	9/19/2008 to 9/19/2013
Norma Monsivais Saint Louis, MO	**RN122376**	On June 23, 2007 Licensee appeared to be intoxicated. Licensee asked her co-workers to supply the urine sample for testing. After it was discovered by staff that she had made attempts to falsify her requested samples a Breathalyzer test was done and was positive with a .153 blood alcohol content. Licensee was directed to enter into a contract and participate in the Employee Assistant Program. On September 11, 2007, two separate breathalyzer tests were performed on Licensee with results of .097 blood alcohol content and .094, respectively.	11/8/2008 to 11/8/2012
Krista M Pritchett Watertown, SD	**PN2000170580**	On June 21, 2005, Licensee withdrew 2 mg of Dilaudid using the name, password and initials of a registered professional nurse. Licensee falsely documented administering 1 mg of Dilaudid and falsely documented wasting the remaining 1 mg of Dilaudid. Licensee misappropriated the 2 mg of Dilaudid for her personal consumption. On June 21, 2005, Licensee withdrew 2 mg of Dilaudid using the name, password and initials of a registered professional nurse employed at the Center. Licensee falsely documented administering 2mg of Dilaudid. Licensee misappropriated the 2 mg of Dilaudid for her personal consumption. On July 2, 2005, Licensee withdrew Dilaudid using the name, password and initials of a registered professional nurse. Licensee falsely documented administering Dilaudid. Licensee misappropriated the Dilaudid for her personal consumption.	11/19/2008 to 11/19/2011
Charris Jonea Rathbone Birch Tree, MO	**PN2005008915**	On January 1, 2008, Licensee left the facility without giving report to the incoming nurse and before Licensee shift was over. Licensee told nurse she was leaving without giving a report.	11/8/2008 to 11/8/2009

Probation continued on page 13

Probation continued from page 12

Name	License Number	Violation	Effective Dates of Probation
Tara C St James Saint Louis, MO	**PN040434**	On March 5, 2006, at approximately 6:50 p.m., a CMT witnessed Licensee holding a resident with both arms and shaking her. The CMT observed Licensee shaking the resident in a back and forth motion while holding the resident's wrists. The CMT heard Licensee say, "Yea take her away because I'm about to lose my license, because I'm getting mad." Another witness stated that the resident wanted to go behind the nurse's desk therefore Licensee got up from her chair to prevent the resident from going behind the nurse's desk. After Licensee wheeled the resident away a couple of times the resident proceeded to get out her chair and grab on to Licensee's clothes at which point Licensee grabbed the resident's wrist and began to shake the resident back and forth. The other witness also heard Licensee yell, "see, you will make me lose my license." Licensee denies holding the resident's wrists and shaking her back and forth and denies making the statement about her license. Due to this incident, Licensee was terminated on March 7, 2006.	9/4/2008 to 9/4/2009
Harriette L Stewart Kansas City, MO	**PN032223**	On June 2, 2007, Licensee documented a 90% oxygen saturation on a resident, when it would have been impossible to ascertain the resident's oxygen saturation level because the Center's only pulse oximeter machine was broken and had been discarded in the trash.	10/8/2008 to 10/8/2009

REVOCATION

Name	License Number	Violation	Effective Dates of Revocation
Joyce A Arrowood Fulton, MO	**RN112173**	On December 20, 2004, Licensee's name was placed on the U.S. Department of Health and Senior Services, Office of Inspector General's Federal Exclusion List until December 20, 2014. In March 2004, Licensee began employment at Ashland as a registered professional nurse and was continuously employed until March 16, 2006, in violation of the OIG exclusion. On February 2, 2004, Licensee began employment at Fulton as a registered professional nurse and was continuously employed until March 14, 2006, in violation of the OIG exclusion.	9/17/2008
Tristi R Carroll Warsaw, MO	**PN053087**	Pursuant to the decision of the Administrative Hearing Commission, Licensee's license is subject to disciplinary action under Section 335.066.2(1), (5), (12) and (14) RSMo.	9/17/2008
Melissa L Diomedes Warrenton, MO	**RN120749**	Licensee was required to contract with NCPS, Inc. to schedule random drug and alcohol screenings. During her disciplinary period, Licensee failed to call NCPS on twelve days. Licensee was required to abstain completely from the use or possession of any controlled substance or other drug for which a prescription is required unless use of the drug has been prescribed by a person licensed to prescribe such drug and with whom Licensee has a bona fide relationships as a patient. On July 15, 2008, Licensee submitted a urine sample for random drug screening. That sample tested positive for the presence of marijuana.	9/18/2008
Carla J Paulson Branson, MO	**RN114231**	Licensee was required to contract with NCPS, Inc. and participate in random drug and alcohol screenings. Licensee failed to complete the contract process with NCPS. Licensee was required to undergo a thorough chemical dependency evaluation. The Board never received a thorough chemical dependency evaluation submitted on Licensee's behalf. Licensee was required to undergo a thorough mental health evaluation. The Board never received a thorough mental health evaluation submitted on Licensee's behalf. Licensee was required to renew her nursing license. Licensee has not renewed her license. Licensee is required to meet with representatives of the Board at regular intervals. Licensee was advised by certified mail to attend a meeting with the Board's representative on July 16, 2008. Licensee did not attend the July 16, 2008 meeting.	9/18/2008
Dawn R Schappe Wentzville, MO	**RN120571**	Licensee was the Director of Nursing at Leland, a skilled nursing facility in University City, Missouri. In April, 2001, two residents of the facility died as a result of hyperthermia. Two other residents with pre-existing medical conditions declined as a result of the excessive heat in the facility and they also died. On April 7, 2006, the Administrative Hearing Commission found that the Board had grounds to discipline Licensee pursuant to §§335.066.2(5) and (12) RSMo. "[s]he failed to adequately monitor residents and failed to adequately instruct her staff to monitor and take actions to protect the residents." "We find that Schappe's failure to adequately supervise her staff and monitor the residents at Leland evidences incompetence."	9/17/2008

Revocation continued on page 14

Revocation continued from page 13

Name	License Number	Violation	Effective Dates of Revocation
Paula Danette Schnelle Savannah, MO	**PN1999138406**	Licensee was required to contract with NCPS, Inc. and participate in random drug and alcohol screenings. Licensee failed to complete the contract process with NCPS. Licensee was required to undergo a thorough chemical dependency evaluation within six weeks of the effective date of the Agreement and have the results sent to the Board within ten days of its completion. The Board never received a thorough chemical dependency evaluation submitted on Licensee's behalf. Licensee was required to keep her nursing license current. Licensee's license expired on May 31, 2008 and has not been renewed.	9/18/2008
Edith M Young Saint Louis, MO	**PN037991**	Licensee was required to meet with representatives of the Board at regular intervals. Licensee was advised by certified mail to attend a meeting with the Boards' representative on April 2, 2008. Licensee failed to attend the meeting or call to reschedule the meeting. Licensee was required to submit employer evaluations from each and every employer. If Licensee was unemployed, a notarized statement indicating the dates of unemployment was to be submitted in lieu of employer evaluations. The Board did not receive an employer evaluation or a statement of unemployment by the first documentation due date of July 2, 2008.	9/18/2008

SUSPENSION

Name	License Number	Violation	Effective Dates of Suspension
Theresa K Thoman Kansas City, KS	**PN049395**	On July 22, 2008, Licensee submitted a urine sample for random drug screening. That sample tested positive for the presence of marijuana.	9/18/2008 to 9/18/2011
Brian J Vargo Farmington, MO	**PN055216**	Licensee initially denied taking Percocet, but then admitted to taking Percocet for his personal use and acknowledged he had a problem with prescription medications.	10/22/2008 to 10/22/2009

VOLUNTARY SURRENDER

Name	License Number	Violation	Effective Dates of Voluntary Surrender
Kathleen M Bailey Saint Louis, MO	**PN058448**	Licensee was required to contract with NCPS, Inc. and participate in random drug and alcohol screenings. Licensee failed to complete the contract process with NCPS. Licensee was required to meet with representatives of the Board. Licensee was advised by certified mail to attend a meeting with the Board's representative on June 11, 2008. Licensee failed to attend the meeting.	9/18/2008
Lucretia Kay Baucom Tarkio, MO	**PN2007025044**	In accordance with the terms of her probation, Licensee was required to contract with NCPS, Inc. to schedule random drug and alcohol screenings. Pursuant to that contract, Licensee was required to call a toll free number every day to determine if she was required to submit to a test that day. Licensee failed to call NCPS, Inc. on fifteen (15) days. Further, on two dates, Licensee called and was advised that she had been selected to provide a urine sample for screening. Licensee failed to report to a laboratory to provide the requested sample. Licensee was required to cause a letter of ongoing treatment evaluation from a licensed mental health professional to be submitted to the Board. The Board did not receive a letter of ongoing treatment evaluation from a licensed mental health professional by the documentation due date.	10/30/2008
Sheri M Charlton Joplin, MO	**PN048734**	A resident refused to get out of bed for dinner. The resident was forced out of bed and placed in a wheelchair. The resident threw himself out of the wheelchair. Licensee directed staff to put the resident back in the wheelchair. Licensee picked the resident up from behind and pulled him down into the wheelchair. Licensee restrained the resident by putting a sheet under one of the resident's legs and tying the sheet behind the chair. Licensee wrongfully and without physicians orders restrained the resident.	10/22/2008
Abby Lee Hess Olathe, KS	**RN2007018175**	Licensee stated, "I originally requested licensure in Missouri in order to be able to attend a four week clinical rotation in Joplin. After receiving the license and noting that there was to be a five year probation period, my clinical instructor/dept chair at the school, advised that it would not be necessary to go to the Joplin clinical and pay for the extra monitoring fees required for the five year period for a brief clinical. My only action to be taking at this time is to voluntarily surrender my Missouri license. I do remain an active participant in KNAP, and have been for over one year." Licensee signed an agreement with the Missouri State Board of Nursing voluntarily surrendering her Missouri license.	11/18/2008
Rebecca A Pickle Winfield, MO	**RN127735**	On January 17, 2006, Licensee misappropriated 2mg of Hydromorphone for her personal consumption. On the same day, Licensee misappropriated four syringes of Hydromorphone for her personal consumption. Again on the same day, Licensee misappropriated four syringes of Hydromorphone for her personal consumption. On January 30, 2006, Licensee misappropriated two tablets of Oxycodone/acetaminophen 5/325 for her personal consumption. On February 7, 2006, Licensee misappropriated two tablets of Oxycodone/ acetaminophen 5/325 for her personal consumption. On the same day, Licensee misappropriated 1mg of Lorazapam for her personal consumption. Again on the same day, Licensee misappropriated 0.5mg of Hydromorphone for her personal consumption. On February 7, 2006, Licensee misappropriated 2mg of Hydromorphone for her personal consumption. On that day, Licensee exhibited impairment while on duty at the Hospital in that she had an unsteady gait, slurred speech, was lethargic, had difficulty gathering her thoughts and spoke in half sentences repeatedly that didn't make any sense. Licensee administered Lovenox to a patient despite a physician's order to hold the medication until after an LP was performed. This resulted in a delay in testing. Licensee failed to assess a post-operative patient and failed to administer insulin per sliding scale as ordered by the patient's physician. On February 9, 2006, Licensee submitted to a drug screen, the results of which were positive for Lorazapam, Hydromorphone, Morphine and Oxycodone. Licensee did not have valid prescriptions for any of the controlled substances.	9/19/2008
Kathy L Raniero Saint Louis, MO	**RN153827**	On or about the week of August 11, 2005, licensee possessed and smoked marijuana.	10/22/2008
Kathleen A Vantrump St Charles, MO	**RN071618**	A pharmacy tech received a prescription for licensee. The pharmacy tech noticed that the label, which typically bears the name of the patient, had been removed and licensee's name was hand-written where the label had been. The pharmacy tech called the prescribing doctor to ascertain the validity of the prescription. The doctor verified that he did not write the prescription for licensee. Licensee admitted to the Board's investigators that she altered the prescription for the purpose of obtaining Percocet. Following the above-referenced occurrence, licensee's employer audited licensee's pyxis activity for the previous thirty (30) days. The audit revealed nine (9) occasions when licensee removed two (2) Percocet tablets without a physician's order and without documenting the administration or waste of the Percocet. When licensee was questioned about the allegation of diverting Percocet, licensee admitted that she withdrew Percocet from the Pyxis for patients who did not have a physician's order and did not document that the medication had administered or wasted. Licensee admitted that she began diverting Percocet in March 2008 and continued to do so until her termination.	10/10/2008

Did you know you are required to notify the Board if you change your name or address?

A change form is available on our website at

http://pr.mo.gov

Joint Statement on Pain Management by the Missouri Board of Healing Arts, Board of Nursing and Board of Pharmacy

December 2008

Pain is one of the oldest medical problems and the most universal physical affliction. It also is one of the most common reasons for people to seek medical attention. Adequate pain management leads to enhanced functioning and increased quality of life. In contrast, inadequately controlled pain can have such profound consequences as disability, depression and despair. In addition, inadequately controlled pain can increase utilization of healthcare resources and expenditures.

The Missouri Boards of Healing Arts, Nursing and Pharmacy are in accord with the Joint Commission on Accreditation of Healthcare Organizations in recognizing that "Patients have the right to appropriate assessment and management of pain." Inappropriate treatment of pain includes non-treatment, undertreatment, overtreatment, and the continued use of ineffective treatments. It is, therefore, incumbent upon Missouri physicians, nurses, pharmacists and other health professionals to work cooperatively and effectively to address the multiple dimensions of pain and to provide maximum pain relief with minimal side effects.

In the interest of the public's health, the Missouri Boards of Healing Arts, Nursing and Pharmacy issue this joint statement. This statement is not intended to define complete or best practice, but rather to communicate guidelines for professional practice. These guidelines are not intended to interfere with a healthcare provider's professional duty to exercise that degree of learning and skill ordinarily possessed by competent members of the healthcare provider's profession.

To effectively assist patients in the management of pain, health care professionals should, within their scope of practice:

- Consistently and thoroughly assess all patients for pain. Identified pain should be evaluated with a complete history and physical, including laboratory and diagnostic testing, if indicated;
- Recognize the individual variables influencing pain and its management, including age, cognitive ability, culture, religion, socioeconomic status, and ethnicity;
- Assess common sequelae of untreated pain, including depression, anxiety, and social isolation;
- Document all aspects of pain assessment and care in a timely, clear, consistent, complete and accurate manner;
- Use a multi-disciplinary approach, when available, to develop and implement an individualized, outcome-based, written treatment plan that incorporates appropriate pharmacologic and/or non-pharmacologic and psychological interventions;
- Regularly evaluate and document the effectiveness of the treatment plan, using a consistent, developmentally appropriate, standardized assessment tool;
- Adjust the treatment plan as necessary to optimize comfort, quality of life, and functionality as defined by the patient and the treatment team;
- Anticipate and effectively manage side effects of pain medications;
- Educate patients, family members, and caregivers with respect to their rights and responsibilities regarding pain and its management;
- Minimize risks of diversion and abuse of controlled substances through appropriate assessment, monitoring, and documentation;
- Recognize that individuals with the disease of addiction may also experience pain and may require the use of analgesics, including opioids. Specialized management and/or referral may be necessary;
- Consult and refer to other providers in cases where patients have pain that cannot be effectively managed;
- Utilize evidence-based policies and protocols for pain management when possible;
- Apply appropriate, up-to-date knowledge and treatment; and
- Comply with all state and federal laws and regulations regarding prescribing, dispensing, and administering prescription drugs, including controlled substances.

Pertinent terms relating to pain management are defined as follows:

Acute Pain

Acute pain is the normal, predicted physiological response to an adverse chemical, thermal or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.

Addiction

Addiction is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as "drug dependence" and "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

Analgesic Tolerance

Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

Chronic Pain

A pain state which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.

Pain

An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical Dependence

Physical dependence on a controlled substance is a physiologic state of neuroadaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.

Pseudoaddiction

Pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

Substance Abuse

Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Tolerance

Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.